Maryland State Board of Dental Examiners
Spring Grove Hospital Center • Benjamin Rush Building
55 Wade Avenue
Baltimore, Maryland 21228
(410) 402-850~~0~~91~~1~~

APPLICATION FOR CERTIFICATION AS A DENTAL ASSISTANT QUALIFIED IN ORTHODONTICS

~~☐ CHECK HERE IF THE ADDRESS ON THE MAILING LABEL IS NOT CORRECT OR IF YOU WISH TO DESIGNATE A DIFFERENT ADDRESS AS YOUR MAILING ADDRESS. COMPLETE SECTION I IF MAILING LABEL IS INCORRECT.~~

Notice For Mailing List:
The information collected on this application form is collected for the purposes of the Board's functions under Annotated Code of Maryland, Health Occupations, Title 4. Failure to provide the information may result in denial of your application. You have a right to inspect, amend, and request correction of this information. The Board may permit inspection of this information or make it available to others only as permitted by federal and State law. Under the Maryland Public Information Act, Annotated Code of Maryland, State Gov't §10-617, the Board may provide, for a fee, a list of licensees' names and addresses to professional associations and other entities. You may request in writing that your name be omitted from such lists.

SECTION I – ~~CHANGE OF~~ NAME AND ADDRESS
Law requires certificate holders to notify the Board of a name or address change within 60 days.

Name (Last, First, Middle Initial):	
Street Address:	
City, State, Zip:	

CHANGE OF INFORMATION: If the above name or address is incorrect, please record changes below. If your name has changed, please submit proof of legal name change (marriage certificate, divorce decree, or other court document certifying a legal name change).

Name (Last, First, Middle Initial):	
Street Address:	
City, State, Zip:	

~~If your name has changed since the last renewal, please enclose proof of name change such as a court document or marriage certificate.~~

~~**REINSTATEMENT FEES – PAYABLE TO MARYLAND STATE BOARD OF DENTAL EXAMINERS**~~
~~Dental Radiation Technologist – $75.00~~

SECTION II – GENERAL INFORMATION

A. Social Security Number: ☐☐☐-☐☐-☐☐☐☐
(There is a statutory requirement that you disclose your social security number. It will be used for identification purposes only.)

B. Date of Birth: ☐☐-☐☐-☐☐☐☐

~~C~~B. Home Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

D~~C~~. Work Phone Number: ☐☐☐-☐☐☐-☐☐☐☐

E~~D~~. E-Mail Address: ☐

~~G~~F. Hispanic or Latino Origin
Are you of Hispanic or Latino Origin? { **Yes** { **No**

G. Race: (Multiracial individuals may select all applicable racial categories). { American Indian or Alaska Native { Asian { Black or African American { Native Hawaiian or other Pacific Islander { White { Other

~~G~~H. Gender: { Female { Male

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H~~I~~E. Licensure in other states:

List other states or jurisdiction in which you hold ~~a dental radiation technologist~~ certification or license. Include certification/license number(s).

State	Certification/License Number

SECTION III - CHARACTER AND FITNESS:

If you answer "YES" to any question(s) in Section III – Character and Fitness, attach a separate page with a complete explanation of each occasion. Each attachment must have your name in print, signature, and date.

YES NO

❒ ❒ a. Has any licensing or disciplinary board of any jurisdiction or any federal or state entity denied your application for licensure, reinstatement or renewal, or taken any action against your license, including but not limited to reprimand, suspension, revocation, a fine, or non judicial punishment?

❒ ❒ b. Have any investigations or charges been brought against you or are any currently pending in any jurisdiction by any licensing or disciplinary board or any federal or state entity?

❒ ❒ c. Has your application for a dentist or dental hygiene license been withdrawn for any reason?

❒ ❒ d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system?

❒ ❒ e. Have you had any denial of application for privileges, failure to renew your privileges or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system?

❒ ❒ f. Have you pled guilty, nolo contendere, had a conviction or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding minor traffic violations?

❒ ❒ g. Have you pled guilty, nolo contendere, had a conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

❒ ❒ h. Are there any criminal charges against you in any court of law, excluding minor traffic violations?

❒ ❒ i. Do you have a physical or mental condition that currently impairs your ability to practice dental hygiene?

❒ ❒ j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

❒ ❒ k. Do you illegally use drugs?

❒ ❒ l. Have you surrendered or allowed your license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal or state entity?

❒ ❒ m. Have you been named as a defendant in a filing or settlement of a malpractice action?

❒ ❒ n. Has your employment been affected or have you voluntarily resigned from any employment, in any setting, or have you been terminated or suspended, from any hospital, related health care or other institution, or any federal or state entity for any disciplinary reasons or while under investigation for disciplinary reasons?

SECTION III - CHARACTER AND FITNESS:

The following questions pertain to the period starting on March 1, 2003 and ending February 28, 2005.

YES NO SINCE MARCH 1, 2003

☐ ☐ a. Has any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal entity denied your application for certification, licensure, reinstatement or renewal, or taken any action against your certificate or license, including but not limited to reprimand, suspension, revocation, a fine, or non judicial punishment?

☐ ☐ b. Have any investigations or charges been brought against you or are any currently pending in any jurisdiction, including Maryland, by any licensing or disciplinary board or any federal entity?

☐ ☐ c. Has your application for certification or licensure been withdrawn for reasons?

☐ ☐ d. Has an investigation or charge been brought against you by a hospital, related institution, or alternative health care system?

☐ ☐ e. Have you had any denial of application for privileges, failure to renew your privileges or limitation, restriction, suspension, revocation or loss in privileges in a hospital, related health care facility, or alternative health care system?

☐ ☐ f. Have you pled guilty, nolo contendere, had a conviction or receipt of probation before judgment or other diversionary disposition of any criminal act, excluding minor traffic violations?

☐ ☐ g. Have you pled guilty, nolo contendere, had a conviction, or receipt of probation before judgment or other diversionary disposition for an alcohol or controlled dangerous substance offense, including but not limited to driving while under the influence of alcohol or controlled dangerous substances?

☐ ☐ h. Are there any criminal charges pending against you in any court of law, excluding minor traffic violations?

☐ ☐ i. Do you have a physical or mental condition that currently impairs your ability to practice dental radiation technology?

☐ ☐ j. Has the use of drugs and/or alcohol resulted in an impairment of your ability to practice your profession?

☐ ☐ k. Do you illegally use drugs?

☐ ☐ l. Have you surrendered or allowed your certificate or license to lapse while under investigation by any licensing or disciplinary board of any jurisdiction, including Maryland, or any federal entity?

☐ ☐ m. Have you been named as a defendant in a filing or settlement of a malpractice action? **If yes, attach a current copy of your National Practitioner Data Bank report.**

☐ ☐ n. Has your employment been affected or have you voluntarily resigned from any employment, in any setting, or have you been terminated or suspended, from any hospital, related health care or other institution, or any federal entity for any disciplinary reasons or while under investigation for disciplinary reasons??

If you answered "YES" to any question(s) in Section III – Character and Fitness, attach a separate page with a complete explanation of each occasion. Each attachment must have your name in print, signature, and date.

SECTION I~~V~~V – REQUIREMENTS FOR ~~RE~~INSTATEMENTCERTIFICATION

❒ ~~a~~b. ~~Dental continuing e~~Education. I have attached documentation substantiating satisfactory completion of an approved educational program in expanded functions of at least 35 hours.~~proof of completion within the 1-year period preceding application for reinstatement of 8 classroom hours of dental continuing education, 4 hours of which are on the subject of radiation safety.~~

Release and Certification:

~~Practice of dental radiation technology without a current certification issued by the Maryland State Board of Dental Examiners is a violation of the Dental Practice Act.~~ I affirm that the contents of this document are true and correct to the best of my knowledge and belief. Failure to provide truthful answers may result in disciplinary action.

I agree that the Maryland State Board of Dental Examiners (the Board) may request any information necessary to process my application for ~~dental radiation technologist~~ certification in Maryland from any person or agency, including but not limited to postgraduate program directors, individual dentists, government agencies, the National Practitioner Data Bank, the Healthcare Integrity and Protection Data Bank, hospitals and other licensing bodies, and I agree that any person or agency may release to the Board the information requested. I also agree to sign any subsequent release for information that may be requested by the Board.

I agree that I will fully cooperate with any request for information or with any investigation related to my practice as a ~~licensed dental radiation technologist~~ Dental Assistant Qualified in Orthodontics in the State of Maryland, including the subpoena of documents or records.

During the period in which my application is being processed, I shall inform the Board within 30 days of any change to any answer I originally gave in this application, any arrest or conviction, any change of address or any action that occurs based on accusations that would be grounds for disciplinary action under the Annotated Code of Maryland, Health Occupations §4-315.

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Applicant Signature **Date**